GAP Supplement

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INTRODUCTION

Beginning January 12, 2015, the Department of Medical Assistance Services (DMAS) will begin a two-year, state wide §1115 demonstration waiver, the *Virginia Governor's Access Plan for the Seriously Mentally Ill (GAP).* Virginia will offer a limited yet targeted package of benefits for individuals who have a serious mental illness (SMI) (as set out by DMAS) and incomes below 100% of the Federal Poverty Level.

The benefit package builds on a successful model of using existing partnerships to provide and integrate basic medical and behavioral health care services. This will enable individuals in the GAP Program to have coordinated access to those services, thereby enhancing treatment and increasing the potential to significantly reduce the severity of their symptoms. The three key goals of this Demonstration are to:

1. Improve access to health care for a segment of the uninsured population in Virginia who have significant behavioral and medical needs;
2. Improve health and behavioral health outcomes of demonstration participants; and,
3. Serve as a bridge to closing the insurance coverage gap for uninsured Virginians.

Services are provided through the existing Medicaid fee-for-service provider networks, and DMAS is continuing to use the service authorization processes currently used for the Medicaid and CHIP/FAMIS programs. DMAS already maintains a strong partnership with Magellan which serves as the Behavioral Health Services Administrator (BHSA) that performs service authorization, claims payment and provider credentialing and enrollment for behavioral health services. With expertise with this population, Magellan is the leading partner in Virginia for behavioral health service network management, service authorization, and claims payment.

GAP covered medical services are billed using the existing Medicaid fee-for-service process and paid at the current fee-for-service Medicaid/CHIP reimbursement rates. Some medical services will require authorization which is performed by the current service authorization contractor, Keystone Peer Review Organization (KEPRO). All benefits and terms of payment (as described in later sections) are specified in a contract document that will be executed with existing partners.

ELIGIBILITY AND ENROLLMENT

The GAP Program targets individuals who meet eligibility parameters resulting from a determination of being seriously mentally ill (SMI). In order to be eligible, individuals must meet ALL of the requirements outlined below, which are reviewed and verified by Cover Virginia.

- Adult ages 21 through 64 years old;
- U. S. Citizen or lawfully residing immigrant;
- Not eligible for any state or federal full benefits health insurance program including, but not necessarily limited to: Medicaid, Children's Health Insurance Program (CHIP/FAMIS), Medicare, or TriCare Federal Military benefits;
- Resident of Virginia;
- Household income that is below 95% of the Federal Poverty Level (FPL) plus a 5% income disregard;
- Uninsured;
- Not residing in a long term care facility, mental health facility, or penal institution; and
- Screened and meet the criteria for GAP SMI.

GAP eligibility determination has two parts; (i) a determination of whether or not the individual meets the GAP SMI criteria, and (ii) a determination of whether or not the individual meets the GAP financial and non-financial eligibility criteria. Individuals may start at either step to enter the GAP Program.

There are two ways to submit an application for GAP to Cover Virginia:

1. Individuals may contact the Cover Virginia GAP Unit telephonically by calling 1-855-869-8190 or TDD line at 1-888-221-1590. Applicants who apply at the GAP Unit and have not had a GAP SMI Screening will be referred to the nearest screening entity to determine if the applicant meets the GAP SMI criteria. Applicants do not need to wait for the financial/non-financial information to be reviewed prior to being referred for the SMI screening.

Or

2. Through the provider assisted web portal accessed through a secure log in provided to the GAP SMI Screening Entity. Individuals may only be assisted by a GAP screening entity or another DMAS approved organization. The GAP SMI screening entities are: Community Services Boards (CSBs), Federally Qualified Health Centers (FQHCs), or hospitals with an inpatient psychiatric unit. This is the preferred method for application.

All applicants will receive a GAP SMI screening in the same manner and consideration without regard to financial or other non-age related eligibility criteria.

GAP SMI criteria is determined via the use of the GAP Serious Mental Illness Screening Tool (DMAS-P-603) which is completed by a DMAS approved GAP screening entity (see Screening Tool in "Exhibits"). The screening tool addresses 5 areas: age, diagnosis, duration of illness, level of disability, and whether due to mental illness the individual requires assistance to consistently access and utilize needed medical and/or behavioral health services/supports.

One of the two screening types listed below must be completed by a DMAS approved screening entity in order to determine GAP SMI eligibility.

1. **Limited Screening**: Conducted for individuals who have had a diagnostic evaluation completed by a Licensed Mental Health Professional (LMHP) (including Supervisees and Residents) within the past 12 months and this evaluation is available to the screener. The GAP SMI Screening Tool (DMAS-P-603) may be completed by either an LMHP (including Supervisees and Residents), Qualified Mental Health Professional-Adult (QMHP-A), or QMHP-Eligible (E). The available evaluation is submitted to Magellan as the required attachment along with the signed and dated DMAS-P-603 form.

   As a rule, these screenings should be conducted face-to-face because the preferred

process includes the screening entity assisting the individual with the application to Cover VA. (Completion via telemedicine is also acceptable.) SMI screenings may however be submitted on behalf of the individual without a face-to-face when all of the following are met:

- The individual has an open and active case with the screening entity;
- The screening entity has the permission of the individual to submit a GAP SMI Screening; and
- There is a mental health diagnostic evaluation on file that was completed by an LMHP (including supervisees and residents) within the past 12 months.

2. **Full Screening**: Conducted for individuals who have not had a diagnostic evaluation completed by an LMHP (including Supervisees and Residents) within the past 12 months or for whom the evaluation is not available to the screener. The signed and dated GAP SMI Screening Tool (DMAS-P-603) and diagnostic evaluation conducted at the time of the screening must be completed by an LMHP (including Supervisees and Residents) and submitted to Magellan. Full screenings must be completed face-to-face. (Completion via telemedicine is also acceptable.)

Provider qualifications for LMHP, LMHP-Supervisees/Residents, QMHP-A, and QMHP-E are located in Chapter II of the Community Mental Health Rehabilitative Services (CMHRS) Manual under "Provider Credentials for Mental Health Services" and 12VAC30-135-410.

GAP SMI Screenings must be conducted within 7 business days from the date of the individual's request for screening or referral from Cover Virginia.

GAP SMI Screening Tools and required attachments are to be submitted to Magellan within three business days of completion for an accuracy review. Magellan will have three business days to determine that the attachments support the items checked on the GAP SMI Screening Tool. GAP SMI screeners are to submit the DMAS-P-603 and required attachments to Magellan regardless of the screener's determined SMI outcome. Once reviewed Magellan will submit the GAP SMI met/not met decision to Cover Virginia in a nightly file.

All GAP applications will be determined no later than 45 days from the date of the application except in cases of unusual circumstances such as administrative or other emergency beyond the agency's control or an incomplete application which can be held open for 30 calendar days to enable applicants to provide outstanding information. Approval/Denial/Deficiency notices of action for eligibility will be sent out the next business day. Appeal rights information will be included on the notice. Eligible applicants will be enrolled in the MMIS system immediately upon determination and in the Magellan system no later than one week following the addition to MMIS.

Applicants who meet both the GAP SMI and financial/non-financial criteria will receive coverage effective on the first day of the same month in which the individual's signed application was received by Cover Virginia, with the exception of applications received in January 2015. For applications received in January 2015 coverage will begin the date that DMAS receives federal approval to begin the GAP demonstration waiver. No retroactive eligibility prior to the application month will be permitted in the GAP demonstration waiver program.

Individuals meeting the eligibility requirements for the GAP program will be enrolled for a period of 12 continuous months except if the individual becomes 65 years of age, moves out of the Commonwealth, or becomes enrolled in Medicare or Medicaid coverage.

The renewal of an individual's eligibility for the GAP program will be reviewed prior to the end of the 12-month coverage period. An additional determination of GAP SMI will not be required to complete the renewal for program eligibility.

VIRGINIA MEDICAID EXPANSION-EFFECTIVE JANUARY 1, 2019

On June 7, 2018, Governor Northam signed the 2018 Virginia Acts of Assembly Chapter 2 (2018 Appropriations Act) authorizing the Department of Medical Assistance Services (DMAS) to amend Virginia's Medicaid State Plan to expand coverage to newly eligible non-disabled, non-pregnant adults ages 19 to 64 with income up to 138 percent of the FPL, effective on January 1, 2019. Because there will be an expanded Medicaid program, the Commonwealth no longer require the GAP program.

Most GAP members will be enrolled automatically into this new program January 1, 2019, if they have remained eligible and current in the GAP program through December 15, 2018.

Unfortunately, due to federal eligibility requirements, only a very small number of GAP members will not be eligible for the new program. The GAP program for the individuals who are not eligible for the Medicaid Expansion program will be ending March 31, 2019.

Eligibility Card

An eligibility card with both the Virginia and GAP logo is issued to individuals to present at the time of service with participating providers. The provider is obligated to determine that the person to whom care or service is being rendered is the same individual listed on the eligibility card. The provider has the responsibility to request such identification as he or she deems necessary. Presentation of the GAP eligibility card is not proof of coverage nor guarantee of payment. A sample of a GAP eligibility card is included under "Exhibits" at the end of this supplement.

Eligibility for GAP benefits must be confirmed each time a service is rendered. The provider must determine if the service is within the dates of eligibility. Benefits are available only for services performed during the indicated period of eligibility. These dates must be checked prior to rendering any service.

Note: GAP benefits will not pay for care or services rendered before the beginning date or after the end date of eligibility.

GAP Coverage Co-payments

There are no premiums, copayments, coinsurance, or deductible charged to individuals who have been found to be eligible for the GAP program.

Additional information regarding Medicaid eligibility is located in Chapter III of the provider manual associated with each covered service.

COVERED SERVICES AND LIMITATIONS

GAP coverage is limited to outpatient medical, behavioral health, pharmacy, GAP case management, and care coordination services for individuals meeting the GAP SMI eligibility

criteria. This program intends that such services will significantly decrease the severity of individuals' SMI so that they can recover, work, parent, learn, and participate more fully in their communities.

A complete benefits chart is located in the exhibits section of this supplemental manual.

Telemedicine

DMAS reimburses for telemedicine services under limited circumstances. Telemedicine is the real-time or near real-time exchange of information for diagnosing and treating medical conditions. Telemedicine utilizes audio/video connections linking medical practitioners in one locality with medical practitioners in another locality. DMAS recognizes telemedicine as a means for delivering some covered Medicaid services. Please refer to the Virginia Medicaid Memo dated May 13, 2014 — Updates to Telemedicine Coverage.

For telemedicine billing codes, refer to Chapter V of the Physician Manual. Questions may be emailed to DMAS at: Vatelmed@dmas.state.va.us.

SERVICES PROVIDED BY MAGELLAN

Care Coordination

Care coordination includes identification of the individual's behavioral health, medical and social/community support needs and the development, implementation, monitoring, and revision (as necessary) of a plan of care to efficiently achieve the individual outcomes in the most cost-effective manner. Care coordination has two main goals: 1) to improve the health and wellness of individuals with complex and special needs; and 2) to integrate services around the needs of the individual at the local level by working collaboratively with all partners, including the individual, family and providers. Care managers will provide information regarding:

- Covered benefits;
- Provider selection; and
- How to access all services including behavioral health and medical and use of preferred pathways to indigent medical and behavioral health services.

Magellan care managers work closely with local CSBs who are providing GAP case management services in order to assist GAP members in accessing needed medical, psychiatric, pharmacy, and other supports as appropriate. The following are among the interventions provided for individuals as part of Care Coordination:

- Member Handbook
- Access to toll-free number 24 hours a day, seven days a week
- Web-based and e-learning material
- Online health literacy materials
- Self-help groups and community-based support groups where available
- Linkages and referrals to community resources
- Recovery Navigation Services where available
- Parent and family support
- Collaborative Treatment Planning

Members may initiate care coordination with or without the assistance of another provider. Individuals are not required to obtain other GAP benefits in order to utilize care coordination and may contact a care manager at 1-800-424-4279 or 1-800-424-GAP9.

Care coordination services through Magellan include two tiers, Community Wellness and Community Connection. These tiers are to optimize the physical, social and mental functioning of individuals by: increasing community tenure, reducing readmissions, enhancing support systems, and improving treatment efficacy through advocacy, communication, and resource management.

Community Wellness (Tier One)

Individuals at this level require the least amount of care coordination. Generally, their needs can be met through short-term assistance from Magellan staff for issues such as follow-up from a crisis call, help in finding a specialty provider, coordination and follow-up with the individual's case manager, or linking to behavioral health services. Magellan will contact and coordinate care with the local CSB and other providers. If the individual has any co-occurring medical and behavioral health conditions Magellan will oversee and monitor the communication and collaboration between the physical health and behavioral health providers to ensure an integrated treatment program for the individual. The goal of this level of support is to solidify the individual's connection with providers, the CSB, and resources for continued care, as well as improve community participation and better

understanding and focus on achieving overall wellness.

Community Connection (Tier Two)

This level of support is designed for individuals with higher level of need, such as those with frequent emergency room visits and hospitalization discharges with high social stressors suggesting a possible risk for hospital readmission. Interventions for these individuals combine technological and clinical resources to enable ongoing participation in treatment. Care coordination services for individuals in the Community Connection level is led by assigned care managers. The average length of support at this level is from 3 to 12 weeks. The minimum contact requirement for Community Connection is a minimum of twice per month. The acuity of the individual's presentation will guide the timeframe and frequency of contacts and interventions.

Crisis Line

Magellan care managers are all licensed mental health professionals. Care managers are available to GAP members 24 hours per day, 7 days per week in case of behavioral health crisis situations. Care managers coordinate with local CSB's crisis intervention teams as well as local law enforcement to assist with the provision of mental health care for acute psychiatric dysfunction requiring immediate clinical attention. The objectives are to prevent exacerbation of a condition and prevent injury to the individual or others until additional services can be administered. Care managers can be reached at 800-424-4279 or 800-424-GAP9.

Recovery Navigation Services

Recovery Navigation services are provided through Magellan. Magellan Recovery Navigation Services are provided by trained Recovery Navigators, who self-disclose as living with or having lived with a behavioral health condition. The goal of Recovery Navigation Services is to make the transition back into the community a successful one and avoid future psychiatric inpatient hospital stays by providing an array of linkages to peer run services, natural supports, and other recovery oriented resources.

Face-to-face recovery navigation services will be available in select areas of the state in which there are a high concentration of peer-run community organizations. It is expected that there will be more frequent face-to-face engagement via the recovery navigation team

compared to clinical team members. These voluntary services are designed to facilitate connections with local peer-run organizations, self-help groups, other natural supports, and to engage individuals in treatment with the appropriate community-based resources to prevent readmission, improve community tenure and meaningful participation in the community of their choice.

A state wide warm-line telephonic recovery navigation resource is available as part of the Recovery Navigation Service. The warm-line is staffed by Recovery Navigators who have specific training to provide telephonic support. It offers extended hours and toll-free access at 1-800-424-4520.

Other recovery navigation services include, but are not limited to:

- Describing and developing a plan for engaging in peer and natural community support resources as part of the recovery process.
- Visiting individuals in inpatient settings to develop the peer relationship.
- Exploring peer and natural community support resources from the perspective of a person who has utilized these resources and navigated multi-level systems of care. These linkages will expand to educating members about organizations and resources beyond the health care systems.
- Initiating rapport, teaching and modeling positive communication skills with individuals to help them self-advocate for an individualized services plan and assisting the individual with the coordination of services to promotes successful community integration strategies.
- Assisting in developing strategies to decrease or avoid the need for future hospitalizations by offering social and emotional support and an array of

individualized services.

- Providing social, emotional and other supports framed around the eight dimensions of wellness:

  - **Emotional**—Coping effectively with life and creating satisfying relationships
  - **Environmental**—Good health by occupying pleasant, stimulating environments that support well-being
  - **Financial**–Satisfaction with current and future financial situations
  - **Intellectual**—Recognizing creative abilities and finding ways to expand knowledge and skills
  - **Occupational**—Personal satisfaction and enrichment from one's work
  - **Physical**—Recognizing the need for physical activity, healthy foods and sleep
  - **Social**—Developing a sense of connection, belonging, and a well-developed support system
  - **Spiritual**—Expanding our sense of purpose and meaning in life

Some recovery navigation services are currently only available in select areas of the state due to limited resources. For information on what supports are offered in your area you may contact Magellan at 1-800-424-4279 or 1-800-GAP9.

Recovery navigation services are not currently reimbursed by DMAS and are only available for GAP members through Magellan.

MEDICAL SERVICES

The limited GAP medical services such as outpatient physician and clinic services, specialist, diagnostic procedures, laboratory procedures, and pharmacy services are covered in the exact same manner as Medicaid. The GAP benefit plan includes limited medical services that require service authorization through DMAS' Service Authorization Contractor, Keystone Peer Review Organization (KEPRO) or the DMAS Medical Support Unit (Please see Appendix D of the Physician Practitioner Manual.). Providers should refer to current manual appendixes, DMAS Medicaid Memos, and the KEPRO or DMAS website for service authorization details since timeliness applies as with current processes.

All services covered in the GAP program must be billed and reimbursed through the existing fee-for-service methodology and claims process.

A complete benefits guide is included in the “Exhibits” section of this supplemental manual.

Outpatient Physician Services and Medical Office Visits, Clinic Services, Specialty Care, Consultation, and Treatment

GAP covered services include evaluation and management, diagnostic and treatment procedures performed in the physician’s office, and medically necessary therapeutic or diagnostic injections.

Information pertaining to provider participation requirements, coverage and limitations, billing, utilization review and control, and service authorization for outpatient physician services and medical office visits, clinic services, specialty care, consultation, diagnostic, and treatment is located in the Physician/Practitioner Manual Chapters II, IV, V, VI, Appendix B, and Appendix D.

Please see the list of non-covered services at the end of this supplement to ensure the service being offered is not a non-covered service.

Outpatient Diagnostic Services

Outpatient diagnostic services includes ultrasound, electrocardiogram, service-authorized CAT, MRI scans and all diagnostic services that can be performed in a physician’s office with the exception of colonoscopy procedures and other services listed as non-covered.

Information pertaining to provider participation requirements, coverage and limitations, billing, utilization review and control, and service authorization for outpatient physician services and medical office visits, clinic services, specialty care, consultation, diagnostic, and treatment is located in the Physician/Practitioner Manual Chapters II, IV, V, VI, and

Appendix D.

Please see the list of non-covered services at the end of this supplement to ensure the service being offered is not a non-covered service.

Outpatient Laboratory and Radiology Services

Information pertaining to provider participation requirements, coverage and limitations, billing, utilization review and control, and service authorization for outpatient laboratory is located in the Independent Laboratory Manual Chapters II, IV, V, VI, and Appendix C.

Please see the list of non-covered services at the end of this supplement to ensure the service being offered is not a non-covered service.

Outpatient Hospital Services

Outpatient hospital procedures are limited to:

- diagnostic ultrasound procedures;
- EKG/ECG including stress tests; and
- radiology procedures unless otherwise listed as a non-covered service.

Information pertaining to provider participation requirements, coverage and limitations, billing, utilization review and control, and service authorization for outpatient hospital coverage is located in the Hospital Manual Chapters II, IV, V, VI, and Appendix D.

Please see the list of non-covered services at the end of this supplement to ensure the

service being offered is not a non-covered service.

Information related to Temporary Detention Orders is located in Appendix B of the Hospital Manual.

Outpatient Pharmacy

Information pertaining to provider participation requirements, coverage and limitations, billing, utilization review and control, and drug utilization review for Outpatient Pharmacy is located in the Pharmacy Manual Chapters II, IV, V, VI, and VII.

Please see the list of non-covered services at the end of this supplement to ensure the service being offered is not a non-covered service.

Outpatient Medical Equipment and Supplies

Outpatient medical equipment and supplies are limited to certain diabetic equipment and supply services. Please see the list of non-covered services at the end of this supplement to ensure the service being offered is not a non-covered service.

Information pertaining to coverage and limitations, billing, utilization review and control, and service authorization for outpatient medical equipment and supplies is located in the Physician/Practitioner Manual Chapters IV, V, VI, and Appendix D. Information is also located in the Durable Medical Equipment & Supplies Manual Chapters II, IV, V, VI, and Appendix B8.

BEHAVIORAL HEALTH SERVICES

All behavioral health services covered in the GAP program must be billed and reimbursed through the existing Magellan Behavioral Health of Virginia methodology and claims process unless specifically stated as otherwise.

GAP Case Management (H0023 UB & UC Modifiers)

GAP Case Management (GCM) is provided statewide by CSB case managers with consultation and support from Magellan care managers and does not include the provision of direct services. Services are targeted to individuals who are expected to benefit from assistance with medication management, and appropriate use of community resources. It is a two tiered service with the provision of either regular or high intensity case management and is focused on assisting individuals with accessing needed medical, behavioral health (psychiatric and substance abuse treatment), social, education, vocational, and other support services.

Service Definition

GCM services are designed to assist individuals in solving problems, if any, accessing needed medical, psychiatric, social, educational, vocational, and other supports essential to meeting basic needs, including:

- assessment and planning services, including developing an individual service plan(ISP) (does not include performing medical and psychiatric assessment but does include referral for such assessment);
- linking the individual to services and supports specified in the ISP;
- assisting the individual face-to-face for the purpose of locating, developing or obtaining needed services and resources;
- coordinating services and service planning with other agencies and providers involved with the individual;
- enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community livings skills, and use vocational, civic, and recreational services;
- making collateral contacts with the individuals' key contacts to promote implementation of the service plan and community adjustment;
- follow-up and monitoring to assess ongoing progress and to ensure services are delivered; and
- education and counseling which guides the individual and develops a supportive relationship that promotes the service plan.

Eligibility Criteria

The individual must meet the GAP criteria of having a serious mental illness and be actively enrolled in the GAP demonstration waiver.

- The individual must require case management as documented on the ISP, which is developed by a qualified GAP case manager and based on an appropriate assessment and supporting documentation.

- An ISP must be in effect which requires regular direct or individual-related contacts and communication or activity with the individual, family, service providers, and/or other key contacts.

Required Activities

- A comprehensive assessment must be completed by a qualified GAP case manager within the first month of the GCM service to determine the need for services. A qualified GAP case manager must meet all of the knowledge, skills, and abilities as a mental health case manager as set out in Chapter II of the Community Mental Health Rehabilitative Services (CMHRS) Manual.

- The GAP case management assessment does not require a service registration.

- GCM assessment and planning services, to include developing an ISP (does not include performing medical and psychiatric assessments, but does include referral for such).

- The GCM must notify the primary care provider (PCP) of the individual's receipt of GAP case management. Notification can be provided via telephone or written contact to the PCP office. In the event an individual does not have a PCP at the time of the GCM assessment the GAP case manager must document efforts by the case manager and individual to locate one. Monthly progress notes must reflect these efforts. Should the individual be unwilling to obtain a PCP, progress notes should reflect ongoing efforts by the case manager in encouraging the individual to incorporate physical wellness and medical checkups into their overall treatment plan.

- The ISP must document the need for GCM and must be fully completed within 30 calendar days of the initiation of the service. The comprehensive assessment must be completed prior to the development of the ISP.

- The GCM shall review the ISP monthly and document that the ISP has been reviewed. The review must be completed by the last day of the month following the month in which the last review was completed.

- GAP case management contact, activity, or communication must be relevant to the ISP. Written plan development, review, or other written work is not a reimbursable GCM activity.

- The GAP case management entity and Magellan must have monthly contact for care coordination activities.

- Linking the individual to needed services and supports specified in the ISP.

- Coordinating services and treatment planning with other agencies and providers.

- Making collateral contacts with key contacts to promote implementation of the service plan.

- Monitoring service delivery as needed through contacts with service providers.

- Education and counseling which guide the individual and develop a supportive relationship that promotes the service plan. Counseling in this context is not psychological counseling, examination, or therapy. The case management counseling is defined as problem-solving activities designed to promote community adjustment and to enhance an individual's functional capacity in the community. These activities

must be linked to the goals and objectives on the case management ISP.

- The GAP case manager may provide education and counseling activities in a group session if the material presented was specifically chosen and designed to meet the identified medical and/or behavioral health needs of the individual and was listed as a specific strategy in the individual's ISP.

- Case management services are intended to be an individualized client-specific activity between the case manager and the individual. There are some appropriate instances where the case manager could offer case management to more than one individual at a time. The provider bears the burden of proof in establishing that the case management activity provided simultaneously to two or more individuals was individual-specific. For example, the case manager needs to work with two individuals, each of whom needs assistance applying for housing benefits. The case manager may work with both individuals simultaneously for the purpose of helping each individual obtain benefits and subsequently follow-up with each individual to ensure that he or she has proceeded correctly.

- A face-to-face contact must be made at least once every 90 days. The purpose of the face-to-face contact is for the case manager to observe the individual's condition, to verify that services which the case manager is monitoring are being provided, to assess the individual's satisfaction with services, to determine any unmet needs, and to generally evaluate the individual's status.

GAP case management services include assistance to GAP participants with finding providers for services, applying for needed community services, and face-to-face interactions to ensure that participants remain engaged in the GAP.

Service Pathways

GAP offers basic coverage for medical and behavioral services, including pharmacy, to individuals who meet the GAP SMI criteria. Many of these individuals are currently served collectively through the indigent care pathways, including through CSBs, the FQHCs, hospitals, the free clinics, and other providers that service indigent populations. Case

managers are expected to use already established indigent behavioral health and medical care providers, in addition to existing resources in the individual's life to help them toward better health outcomes and an improved quality of life.

GAP beneficiaries may choose their own providers. GAP case managers may assist with providing the individual with information so that the individual may make an informed choice; for example, these providers are on the bus line, these providers can provide bubble packs for your medication, etc. The individual may either stay with the indigent care provider or select a GAP provider.

Magellan is available to assist the GAP individual or case manager with identifying behavioral health providers. This can be done via the Magellan website provider search at www.magellanofvirginia.com or by contacting Magellan by phone. Magellan will also know of other behavioral health services the individual may already have a service authorization for or if they have had an authorization with another provider at some point previously and refer the individual to that service or provider.

Additionally Magellan is available to assist the GAP case manager to identify medical health care providers. The GAP case manager may contact Magellan who has access to the DMAS VAMMIS system which will identify Medicaid enrolled health care providers in the locality of the GAP member. Contact information for the local providers will be provided to the GAP case manager who then links/refers the individual to an appropriate provider. GAP members may also contact Magellan for information by calling 1-800-424-4279 or 1-800-424-GAP9.

The GCM may also contact Magellan to inquire as to whether there are any medical or pharmacy claims for the individual in order to help determine whether the individual is keeping PCP or specialist appointments, picking up medications from the pharmacy, obtaining diabetic supplies, etc.

Service Units and Maximum Service Limitations

- Regular intensity GCM shall be billed if the minimum required activities of active GAP case management have been met.

- High Intensity GCM shall be billed for any month in which the regular intensity GCM requirements have been met AND there is a face-to-face contact with the individual during that month that takes place in a community setting outside of the case management office.

- GCM reimbursement rates are as follows:

  1 Unit = 1 Calendar month

  Regular Intensity GCM (H0023, UB modifier) - $195.90 per unit

  High Intensity GCM (H0023, UC modifier) - $220.90 per unit

- Urban and rural rates do not apply for GCM

- A billing unit is one calendar month.

- Billing can be submitted for GAP case management only for months in which direct or client-related contacts, activity, or communications occur. These activities must be documented in the clinical record. The provider should bill for the specific date of the activity or the date the monthly summary note has been documented.

- In order to support the 1 billing unit per calendar month for high intensity GCM, the face to face visit must be performed on the date billed or the specific date the monthly summary note is completed, AND there must be contacts made and documented within that same month. In order to bill for regular intensity GCM, required activities and contacts must occur during the month and be appropriately documented as previously referenced. Providers are NOT to span the month for GAP CM services.

- Reimbursement shall be provided only for "active" case management individuals. An active individual for GAP case management shall mean an individual for whom there is a current ISP that requires regular direct or client-related contacts or activity or communication with the individual or families, key contacts, service providers, or others. Billing can be submitted only for months in which direct or individual-related contacts, activity or communications occur.

- Federal regulation 42CFR441.18 prohibits providers from using case management services to restrict access to other services. An individual cannot be compelled to receive case management if he or she is receiving another service, nor can an individual be required to receive another service if they are receiving case management. For example, a provider cannot require that an individual receive case management if the individual also receives medication management services.

- No other type of case management, from any funding source, may be billed concurrently with GAP case management.

- Reimbursement for GAP case management services for individuals in Institutions for Mental Disease (IMD) is not allowed. An IMD is a facility that is primarily engaged in the treatment of mental illness and is greater than 16 beds.

- There is no maximum service limit for case management services except case management services for individuals residing in institutions or medical facilities. Case management services may not be provided for institutionalized individuals. Services rendered during the time the individual is not admitted to the IMD may be billed, even if during the same month as the admission to the IMD.

- To bill for case management services for individuals that are in an acute care inpatient psychiatric units, two conditions must be met. The services may not duplicate the services of the hospital discharge planner, and the community case management services provided to the individual are limited to one month of service, 30 days prior to discharge from the facility. Case management for hospitalized individuals may be billed for no more than two non-consecutive pre-discharge periods in 12 months.

- Case management services for the same individual must be billed by only ONE type of case management provider.

Service Registration

While service authorization for GAP Case Management is not required, registration of this service with Magellan is required.

Registration is a means of notifying Magellan that an individual will be receiving GAP case management services, thereby avoiding duplication of services and ensuring informed care coordination. Providers should register the start of GAP Case Management within two (2) business days of the service start date.

Registration may occur electronically, by phone or fax. Required elements to provide Magellan include: (1) the individual's name and GAP identification number; (ii) the specific service to be provided, the relevant procedure code and modifier, begin date of the service, and the amount of the service that will be provided; and (iii) the provider's name and NPI, a provider contact name and phone number, and email address.

Case Management Agency Requirements

1. The service specific provider intake and subsequent re-assessments of the individual's medical, mental, and social status must be reflected with appropriate documentation. The initial comprehensive service specific provider intake must also include current documentation of a medical examination, a psychological/psychiatric evaluation, and a social assessment.

2. All ISPs (originals, updates, and changes) must be maintained for a period not less than five years from the date of service or as provided by applicable state laws, whichever is longer. The individual or legal representative must sign the ISP.

3. There must be documentation that the choice of a provider has been offered when services are initiated and when there are changes in services. The choice must be documented in writing by having the individual (or parent or guardian when appropriate) sign a document verifying freedom of choice of providers was offered and this provider was chosen.

4. A release form must be completed and signed by the individual for the release of any information.

5. Case management records must include the individual's name, dates of service, name of the provider, nature of the services provided, achievement of stated goals, if the individual declined services, and a timeline for reevaluation of the plan. There must be documentation that notes all contacts made by the case manager related to the ISP and the individual's needs.

Psychosocial Rehabilitation (H2017)

All information pertaining to provider qualifications, service definition, eligibility criteria, required activities, limitations, discharge criteria, billing, utilization review, and service authorization for Crisis Stabilization Services is located in the Community Mental Health Rehabilitative Services (CMHRS) Manual Chapters II, IV, V, VI, and Appendix C.

Service Registration through Magellan is required for Psychosocial Rehabilitation Services.

Crisis Intervention (H0036)

Crisis intervention services shall only be rendered by a Licensed Mental Health Professional (LMHP), LMHP-supervisee, LMHP-resident, LMHP-Resident in Psychology, or a certified pre-screener.

Unless otherwise specified above all additional information pertaining to provider

qualifications, service definitions, eligibility criteria, required activities, limitations, discharge criteria, billing, utilization review, and service registration for Crisis Intervention is located in the Community Mental Health Rehabilitative Services (CMHRS) Manual Chapters II, IV, V, VI, and Appendix C.

Service Registration is required for Crisis Intervention.

Crisis Stabilization (H2019)

All information pertaining to provider qualifications, service definition, eligibility criteria, required activities, limitations, discharge criteria, billing, utilization review, and service authorization for Crisis Stabilization Services is located in the Community Mental Health Rehabilitative Services (CMHRS) Manual Chapters II, IV, V, VI, and Appendix C.

Service Authorization through Magellan is required for Crisis Stabilization for individuals enrolled in GAP.

ADDICTION RECOVERY AND TREATMENT SERVICES (ARTS)

On April 1, 2017, Virginia's Medicaid program launched an enhanced substance use disorder treatment benefit - **Addiction and Recovery Treatment Services (ARTS).** The ARTS benefit provides treatment for those with substance use disorders across the state. The ARTS benefit expands access to a comprehensive continuum of addiction treatment services for all enrolled members in Medicaid, FAMIS, FAMIS MOMS and the Governor's Access Plan (GAP), including expanded community-based addiction and recovery treatment services and coverage of inpatient detoxification and residential substance use disorder treatment.

For GAP, the following chart reflects the ARTS services covered by GAP:

Service/Level of Care	Manual Reference	Differences in GAP
Screening Brief Intervention and Referral to Treatment (ASAM Level 0.5)	Addiction Recovery and Treatment Services (ARTS) Manuals Chapters II, IV, V, VI, and Appendix A.	Follows ARTS coverage

Opioid Treatment Services (ASAM Level OTS)	Addiction Recovery and Treatment Services (ARTS) Manuals Chapters II, IV, V, VI, and Appendix A.	Follows ARTS coverage
Office Based Opioid Treatment (OBOT)	Addiction Recovery and Treatment Services (ARTS) Manuals Chapters II, IV, V, VI, and Appendix A.	Follows ARTS coverage
Outpatient Services (ASAM Level 1)	Addiction Recovery and Treatment Services (ARTS) Manuals Chapters II, IV, V, VI, and Appendix A	Follows ARTS coverage
Intensive Outpatient Services (ASAM Level 2.1)	Addiction Recovery and Treatment Services (ARTS) Manuals Chapters II, IV, V, VI, and Appendix A.	Follows ARTS coverage
Partial Hospitalization Services (ASAM Level 2.5	Addiction and Recovery Treatment Services (ARTS) Manual Chapters II, IV, V, VI, and Appendix A.	Follows ARTS coverage
Clinically Managed Low Intensity Residential Services (ASAM Level 3.1)	Addiction and Recovery Treatment Services (ARTS) Manual Chapters II, IV, V, VI, and Appendix A.	Follows ARTS coverage
Clinically Managed Population-Specific High Intensity Residential Services (ASAM Level 3.3)	Addiction and Recovery Treatment Services (ARTS) Manual Chapters II, IV, V, VI, and Appendix A.	Follows ARTS coverage
Clinically Managed High-Intensity Residential Services (Adult) (ASAM Level 3.5)	Addiction and Recovery Treatment Services (ARTS) Manual Chapters II, IV, V, VI, and Appendix A.	Follows ARTS coverage
Medically monitored intensive inpatient services (Adult) (ASAM Level 3.7)	Addiction and Recovery Treatment Services (ARTS) Manual Chapters II, IV, V, VI, and Appendix A.	Follows ARTS coverage

Addiction and Recovery Treatment Services (ARTS) Peer Support Services	Addiction and Recovery Treatment Services (ARTS) Manual Chapters II, IV, V, VI, and Appendix A.	If a GAP enrollee elects to transition out of Recovery Navigation services through BHSA and receive MH Peer Support Services, the BHSA recovery navigator should assist with the transition from BHSA-provided peer support navigation. The transition period may last up to 30 consecutive calendar days and address discharging from recovery navigator services and engagement in peer support services.

Peer Support Services

The provision of Peer Support Services facilitates recovery from serious mental illnesses and/or substance use disorders. Peer Support Services are an evidence-based mental health model of care in which a qualified peer support provider assists individuals with their recovery from mental health and substance use disorders. Recovery is a process in which individuals are able to live, work, learn and fully participate in their communities. Peer Support Services will be delivered by peers who have been successful in the recovery process, and can extend the reach of treatment beyond the clinical setting into an individual's community to support and assist continued engagement in the recovery process. The experiences of peer support providers are an important component in the delivery of a comprehensive mental health and substance use services. GAP started covering Peer Support services July 1, 2017.

The Peer Support Services policy manual is published as a Supplement to the appropriate DMAS Provider Manuals including Addiction and Recovery Treatment Services (ARTS), Community Mental Health and Rehabilitation Services (CMHRS), Residential Treatment Services, Psychiatric Services, and Hospital Provider manuals and can be located on the provider portal.

NOTE: If a GAP enrollee elects to transition out of Peer Navigation Services through the BHSA and receive MH or ARTS Peer Support Services, the BHSA peer support navigator shall assist with the transition from BHSA-provided peer support navigation. The transition period may last up to 30 consecutive calendar days and address discharging from recovery navigator services and engagement in peer support services.

Psychiatric Evaluation and Outpatient Therapy

Outpatient psychotherapy services shall be covered consistent with limitations and requirements outlined in the Psychiatric Services Manual. Psychiatric evaluation and outpatient individual, family, and group therapies for mental health and ARTS are covered under GAP.

Additional information pertaining to provider qualifications, service definitions, eligibility criteria, required activities, limitations, discharge criteria, billing, utilization review, and service authorization for psychiatric evaluation and outpatient therapy can be found in the Psychiatric Services Manual Chapters II, IV, V, VI, and Appendix C and the ARTS Manual.

Service limits outlined in the Psychiatric Services Manual pertaining to the number of yearly visits do not apply to individuals enrolled in GAP. There are no maximum benefit limitations on traditional behavioral health psychotherapy services; however service authorization following the first 26 visits in the first year after benefits are obtained is required.

Reimbursement shall be provided in a tiered manner for physicians, psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, and licensed clinical nurse specialists-psychiatric consistent with 12VAC30-80-30(A)(3).

Please see the list of non-covered services at the end of this supplement to ensure the service being offered is not a non-covered service.

NOTIFICATION REQUIREMENTS

Whenever an adverse action is taken, the individual receiving services must receive written

notification of the pending action at least 10 days before the effective date of the action, except for the following:

1. Advance notice will be reduced to five days if the facts indicate the action is necessary because of probable fraud; and

2. Advance notice does not need to be sent if:

- The individual has stated in writing that he or she no longer wishes to receive GAP services;

- The individual gives information that requires the termination of GAP, and the member knows that this action is the result of giving the information;

- The individual has been admitted to an institution where he or she is ineligible for services under GAP;

- The individual moves to another state; or

- The individual's whereabouts are unknown. The agency will determine that the individual's whereabouts are unknown if mail sent to the member is returned as undeliverable.

NON-COVERED SERVICES

The following is a list of services that are not covered by GAP:

Non-covered Medical Services

- Any medical service not otherwise defined as covered in Virginia's State Plan for Medical Assistance Services.

- Chemotherapy
- Colonoscopy
- Cosmetic procedures
- Dental
- Dialysis
- Durable medical equipment (DME) and supply items (other than those required to treat diabetes)
- Early and Periodic Screening Diagnosis and Treatment (EPSDT) services
- Emergency room treatment
- Hearing aids
- Home health (including home IV therapy)
- Hospice
- Inpatient treatment
- Long-term care including home and community based waiver services, custodial care facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Nutritional supplements
- OB/maternity care including birthing centers (gynecology services are covered)
- Orthotics and prosthetics
- Outpatient hospital procedures (other than the following diagnostic procedures)
    - Diagnostic ultrasound procedures
    - EKG/ECG, including stress
    - Radiology procedures (excludes PET and Radiation Treatment procedures)
    - PT, OT, and speech therapies
- Private duty nursing
- Radiation therapy
- Routine eye exams (to include contact lenses and eyeglasses)
- Services from non-enrolled Medicaid providers
- Services not deemed medically necessary
- Services that are considered experimental or investigational
- Sterilization (vasectomy or tubal ligation)
- Transportation – emergency and non-emergency

Non-covered Behavioral Health Services

- Any behavioral health or substance use treatment services not otherwise defined as covered in Virginia's State Plan for Medical Assistance Services
- Day treatment partial hospitalization
- Electroconvulsive therapy and related services (anesthesia, hospital charges, etc.)
- Emergency room services
- EPSDT services including multi-systemic ABA treatment
- Hospital observation services

- Intensive in-home services
- Intensive community treatment (PACT)
- Inpatient hospital or partial hospital services
- Mental health skill-building services
- Psychological and neurophysiological testing
- Residential treatment services (Level A, B and C)
- Services specifically excluded under the State Plan for Medical Assistance
- Services not deemed medically necessary
- Services that are considered experimental or investigational
- Services from non-enrolled Medicaid providers
- Smoking and tobacco cessation and counseling
- Therapeutic day treatment
- Treatment foster care case management (TFC-CM)
- Transportation – emergency and non-emergency
- VICAP assessments

PROVIDER APPEALS

The DMAS Appeals Division maintains an appeal process for enrolled GAP providers of GAP services who have rendered services and are requesting to challenge an adverse decision. The appeal process is available to (i) enrolled GAP service providers that have rendered services and have received a denial in whole or part for GAP covered services, and (ii) enrolled GAP service providers who have received a Notice of Program Reimbursement or overpayment demand from DMAS or its contractors.

Unless otherwise specified above, department provider appeals shall be conducted in accordance with DMAS provider appeal regulations at 12VAC30-20-500 *et. seq,* the Code of Virginia at §32.1-325 *et. seq,* and the Virginia Administrative Process Act §2.2-4000 *et. seq.*

Providers shall not have the right to appeal this GAP program's loss of funding and subsequent denial of services for all applicable individuals.

A notice of appeal is considered filed when it is date stamped by the DMAS Appeals

Division. The notice must identify the issues being appealed. Notices of appeal must be sent to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street, 6th Floor

Richmond, VA 23219

The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. on dates when DMAS is open for business. Documents received after 5:00 p.m. on the deadline date shall be untimely.

CLIENT APPEALS

The Code of Federal Regulations at 42 CFR §431, Subpart E, the Virginia Administrative Code at 12VAC30-110-10 through 12VAC30-110-370, and 12VAC-30-135-487 through 12VAC30-135-495 require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid client or by an authorized representative on behalf of the client. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was mailed, services may continue during the appeal process. However, if the agency's action is upheld by the hearing officer, the client may be expected to repay DMAS for all services received during the appeal period. For this reason, the client may choose not to receive continued services. The entity that took action (Cover Virginia or the service authorization contractor) will be notified by DMAS to reinstate services if continuation of services is applicable. If services are continued or reinstated due to an appeal, they must continue until a decision is rendered by the hearing officer.

Appeals must be requested in writing and postmarked or submitted within 30 days of

receipt of the notice of adverse action. The client or his authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, or by calling (804) 371-8488.

A copy of the notice or letter about the action should be included with the appeal request.

The appeal request must be signed and mailed to the:

Appeals Division

Department of Medical Assistance Services

600 E. Broad Street

Richmond, Virginia 23219

Appeal requests may also be faxed to: (804) 452-5454

The Appeals Division will notify clients of the date, time and location of the appeal hearing if the appeal is valid and a hearing is granted. The hearing will be conducted by a DMAS hearing officer. Most hearings will be done by telephone.

The hearing officer's decision is the final administrative decision by DMAS. If the client does not agree with the hearing officer's decision, he/she may appeal it directly to the Circuit Court in the city or county of residence.

SOURCES OF INFORMATION

General questions regarding the GAP program and regulatory interpretation may be submitted to DMAS via e-mail at BridgetheGAP@dmas.virginia.gov. For specific questions pertaining to services and billing providers are encouraged to contact:

- **Magellan Behavioral Health of Virginia**

Providers of behavioral health services may check GAP member eligibility, behavioral health claims status, behavioral health check status, behavioral health service limits, and behavioral health service authorizations by visiting www.MagellanHealth.com/Provider. If you have any questions regarding behavioral health services, service authorization, or enrollment and credentialing as a Medicaid behavioral health service provider please contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4046 or TDD 1-800-424-4048 or by visiting www.magellanofvirginia.com or submitting questions to VAProviderQuestions@MagellanHealth.com.

- **Keystone Peer Review Organization (KEPRO)**

For medical service authorization questions, providers may contact KEPRO at providerissues@kepro.com. KEPRO may also be reached by phone at 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

KEPRO's website has information related to the service authorization process for all Medicaid programs that they review. Fax forms, service authorization checklists, trainings, methods of submission and much more are on KEPRO's website. Providers may access this information by going to http://dmas.kepro.com.

- **Virginia Medicaid Web Portal**

DMAS offers a web-based Internet option to access **medical and pharmacy** information GAP member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the State Healthcare Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays.

The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

- **Medical and Pharmacy "Helpline"**

The DMAS "HELPLINE" is available to answer medical and pharmacy questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

EXHIBITS

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